

STATE OF IDAHO
DEPARTMENT OF INSURANCE
700 WEST STATE STREET, 3rd FLOOR
PO BOX 83720
BOISE, ID 83720-0043

FOR DEPARTMENT USE ONLY 0560

SELF-FUNDED HEALTH CARE PLANS
STATEMENT OF BACK TAXES DUE

COMPANY NAME	
MAILING ADDRESS	FOR CALENDAR YEAR ENDING:

NUMBER OF BENEFICIARIES COVERED PER MONTH:

JANUARY	_____	JULY	_____
FEBRUARY	_____	AUGUST	_____
MARCH	_____	SEPTEMBER	_____
APRIL	_____	OCTOBER	_____
MAY	_____	NOVEMBER	_____
JUNE	_____	DECEMBER	_____
TOTAL BENEFICIARIES		_____	

1. TOTAL TAXES = TOTAL BENEFICIARIES _____ X .04 \$ _____

2. BALANCE DUE - Make check payable to: **Idaho Department of Insurance**

Your canceled check is your receipt.

There will be a \$20.00 charge on all returned checks. Idaho Code § 28-22-105

\$ _____

Under penalty of perjury, I declare that this statement (including any accompanying schedules and statements) has been examined by me and to the best of my knowledge and belief is a true, correct, and complete return.

Contact Person

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Telephone Number

Ext. _____

Signature of Officer

Date

Name and Title (Type or Print)